FINAL EVALUATION

Maternal and Child Nutrition and Integrated Communications (MCN/IC) Project

(September 28, 2000 to November 30, 2004)

Tajikistan, Gorno-Badakhshan Autonomous Oblast

Aga Khan Foundation U.SA.
(Cooperative Agreement Number: FAO-A-00-00-00033-00)

Principal Author:

Marcie Rubardt, Consultant

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1. Zoirbek Kurbonshoev – Health Sector Reform
2. Malohat Shoinbodova , Evaluation, Learning and Communication Officer
3. Shukurbekova Irina – GMP Officer
4. Sadonshoeva Guldarbogh – Monitoring Officer
5. Zarifkhonova Zebogul – Communication and Training Officer
6. Sherzamonova Nozanin – Chief Pharmacist
7. Alibekov Alibek – RPPM Project Manager
8. Ian Higenbothom ,AKF Intern

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The following individuals were involved in editing this report.

Kate Straub – Reproductive Health and Child Survival Advisor, AKF Tajikistan
John Tomaro – Director, Health Programs, AKF
Terri Lukas – Health Programs Officer, AKF USA

ACRONYMS

AKDN	**Aga Khan Development Network**
AKHS	**Aga Khan Health Services**
AKF	**Aga Khan Foundation**
ARI	**Acute Respiratory Infection**
BCC	**Behavior Change Communication**
CHLS	**Center for Healthy Lifestyle**
CHP	**Community Health Promoters**
DIP	**Detailed Implementation Plan**
DM	**District Monitor**
DOH	**Department of health**
FP	**Family Planning**
GBAO	**Gorno-Badakshan Autonomous Oblast**
GMP	**Growth Monitoring Promoter**
IMCI	**Integrated Management of Childhood Illness**
IUD	**Intra-uterine device**
LQAS	**Lot Quality Assurance Sampling**
MCN/IC	**Maternal/Child Nutrition and Integrated Communications Project**
MSDSP	**Mountain Societies Development support Program**
ORS	**Oral Rehydration Solution**
PHC	**Primary Health Care**
RHCS	**Reproductive health Child Survival (project)**
RPPM	**Rational Pharmaceutical Policy and Management**
STI	**Sexually Transmitted Infection**
TIPS	**Trials in Improved Practices**
USAID	**United States Agency for International Development**
VO	**Village Organization**

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Executive Summary

The Maternal /Child Nutrition And Integrated Communications Project (MCNIC) is a centrally funded four year child survival project benefiting 49,880 women of reproductive age and 25, 485 children aged 0-59 months. The goal of this project was to improve the health and nutritional status of women and children in the Gorno-Badakshan Autonomous Oblast (GBAO) in Tajikistan. It proposed to do this by implementing behavior change communications techniques and training to:

- Improve management of childhood diarrhea and ARI
- Implement community based growth monitoring activities
- Improve use of contraceptives and reproductive health services
- Promote the use and supply of quality and affordable iodized salt
- Implement micronutrient supplementation.

This project used a well-developed behavior change communication approach along with a cadre of community-level volunteers to promote knowledge and practice of preventive health behaviors at the household level. It complemented these efforts with training and mobilization of primary health care staff in the same interventions. This project was also enhanced by the concurrent implementation of three other health projects:

- strengthening drug procurement and distribution systems to assure the availability of essential drugs at the primary care centers,
- health sector reform focusing on the Oblast and district levels, and
- strengthening hospital-based services at the regional and district levels.

Main accomplishments of this project include:

- Changes in household knowledge and behavior for breast feeding, complementary feeding, immunization, diarrhea management, recognition and referral of danger signs for diarrhea and respiratory illness, use of family planning, use of iodized salt and prevention of STIs and HIV/AIDS.
- The establishment of a community volunteer cadre of 160 community health promoters and 300 growth monitoring volunteers reaching villages throughout the region with health promotion and behavior change interventions.
- Development of well-considered approaches in monitoring and evaluation, nutrition management, community health promoter interventions, behavior change communication, and micronutrients with the help of outside technical assistance or specialized staff.
- Training primary health care staff in 193 primary care centers in case management of growth faltering, diarrhea and acute respiratory illness, as well as in health promotion messages for all the project interventions.
- Increased availability of iodized salt throughout the region distributed through volunteer organizations on a cost-recovery basis.
- Development of District Monitors responsible for monitoring and supervision of PHC and community activities.
- Renovation of 123 primary health care facilities (medpoints and ambulatorias) and the provision of basic equipment for 193 primary health care facilities.

The quantitative Health and Nutrition (HNS) survey which was completed in August, 2004, strongly corroborates the observations of the evaluation. Highlights of the most significant results are:

- Children 0-6 months who were immediately breast fed went from 72% in 2001 to 90.5% in 2004. Exclusive breast feeding in the same children went from 58.5% in 2001 to 81% in 2004.
- % of children under five who are underweight decreased from 35% in 2001 to 23% in 2004.
- % of households with iodized salt went from 2.5% in 2000 to 77% in 2004. Children (aged 6 – 12 years) with normal urinary iodine levels increased from 47% in 2001 to 69% in 2004..
- % of children receiving at least one course of worm medicine went from 0 in 2001 to 92% in 2004.
- % of women reporting use of modern family planning methods went from 38% in 2001 to 45% in 2004. The reported use of IUDs decreased, indicating an increase in method choice.
- % of children receiving extra liquids during illness went from 22% in 2001 to 70% in 2004.
- % of mothers citing condoms as a way to prevent STI infections went from 18% in 2001 to 41% in 2004.

The main limitation of this project was the failure to effectively plan for a gradual phasing out/over of its activities by the end of the project. AKF had a tendency to implement the activities on its own without encouraging partners' responsibility for joint support of the activities, particularly at the community level. In spite of efforts at more senior levels to convince people to the contrary, both partners and staff at lower levels tend to believe that the Aga Khan Foundation will always provide support. This made it difficult, for mid-level staff, much less the DOH partners they were working with, to believe that a rigorous sustainability plan was essential.

The main recommendations or lessons learned for future replication revolved around strengthening the support structures and systems within the Department of Health to facilitate community-level activities and reinforcing collaboration between different community cadres for implementing and supporting primary health activities. A variety of specific suggestions were developed, most of which fall within these two focus areas.

Background and Overview

The goal of the Maternal And Child Nutrition And Integrated Communications Project (MCNIC) was to improve the health and nutritional status of women and children in the Gorno-Badakshan Autonomous Oblast (GBAO) in Tajikistan. It proposed to do this by implementing behavior change communications techniques and training to:

- Improve management of childhood diarrhea and ARI
- Implement community based growth monitoring activities

- Improve use of contraceptives and reproductive health services
- Promote the use and supply of quality and affordable iodized salt
- Implement micronutrient supplementation.

This project was complemented by the implementation of three other concurrent health projects. Two of these: Health Sector Reform and Rationalizing Pharmaceutical Policy and Management, (and Reproductive Health / Child Survival) were funded under a Matching Grant which also just finished. The third is Essential Hospital Services, strengthening the regional and district hospitals, which is being implemented under Aga Khan Health Services (AKHS). There were previous projects in school health education and health management information system strengthening that also complemented this project.

The GBAO is an area challenged by extreme conditions: winters are long with many areas of the Oblast closed due to snow for 4-5 months per year, the climate in many areas is harsh, and in the upper half of the area, with an altitude of over 12,000 feet, the population is sparse and there is a paucity of cultivable land. The area received significant support during the time of the Russians, including food and resources for infrastructure development, health and education. Many Badakshanis fondly recall the Russians and the help they provided.

With the withdrawal of the Russians, hunger became rampant and the native Pamiris were persecuted and killed in many parts of the country. The returning displaced persons only added to the strain on the area's resources.

Aga Khan Foundation began providing humanitarian assistance in the area in 1994. They began health interventions in 1998 with the Matching Grant from USAID. In 2000, the Child Survival grant, currently being evaluated, was added.

The challenging environment meant the project was slow to get started. Communication and transport were extremely difficult between Dushanbe and Khorog, recruitment, particularly of ex-patriate staff was delayed due to difficulties in finding people willing to live in isolated and basic conditions, and the local staff that were available, while doctors, had no experience in public health or community mobilization. As a result, the project approaches had to be developed as the staff became more aware of the vision. Finally, the bombing of the Trade Towers and evacuation of ex-patriate staff also delayed the project. The project only really got going after late 2001, which make its achievements even more remarkable.

Evaluation Methodology

This evaluation was carried out jointly with that of the Matching Grant. There were two team leaders, with the other team leader focusing primarily on the health sector reform and the pharmaceutical projects, while this author focused on the reproductive health / child survival project. Data collection was carried out in a coordinated way, while analysis and conclusions were developed with the participation of the project staff who were most involved with each aspect of the program.

This evaluation benefited significantly from the completion of a large-scale Health and Nutrition Survey which was carried out by the project in August, 2004. It provided extensive data at the District level on changes in health behaviors and health status. This could then be compared to similar data that had been collected in 2001. The significant changes found in the survey add considerable strength to the qualitative conclusions drawn by the evaluation team.

In addition to the survey, this project had extensive documentation for all its activities. This included both guideline documents for its interventions (criteria for volunteer selection, training materials, supervision check lists, etc.) and reports on project activities (TIPS research, consultancy reports, behavior change strategy, LQAS survey results, etc.) These were in addition to the routine project documents such as the implementation plan, annual reports, and midterm evaluation. These documents gave a clear idea of the thoroughness and technical quality found in project interventions.

Finally, the qualitative phase of the evaluation took a participatory approach: involving both senior and field project staff in all phases of the evaluation process. This provided an opportunity for staff to essentially do a self-critique of their program under the guidance of the evaluator. It is hoped that this level of participation will increase the likelihood that the recommendations and lessons learned might be applied during future phases of the project.

There were three steps to the qualitative phase of the evaluation:

1. Preparation which included team discussion of the goals and questions to be addressed during the evaluation, preliminary presentation of the different projects and their activities, and finalization of the evaluation tools. Question guides are attached in Annex 6.

2. Data Collection – This involved a smaller group of staff that was divided into two teams in order to maximize completion of the multiple interviews at each site visit. Teams took turns interviewing different cadres of people, and there was also some exchange of team members depending on the evaluators' need for staff expertise in different interviews. However, all team members ended up with a good sense of all aspects of the project. A list of the core team members is included in Annex 3.

3. For analyzing the data, the teams first reviewed and synthesized the data they collected according to the different themes addressed in this report. An expanded group involving all field staff then developed recommendations to address the challenges that were identified. Finally, stakeholders were invited to review, discuss, and adjust the conclusions and recommendations. These included the Oblast Department of Health, MSDSP (Mountain Societies Development Support Program), and Aga Khan Health Services (AKHS). A list of people's expectations for this workshop is included in Annex 7.

It is important to acknowledge that even though funding for this project is finished by the end of November, the future funding status for activities was still not clear. AKF staff are looking for additional funds either internally or from other donors. As a result, recommendations were made assuming the possibility of some continued level of funding. However, it was not possible to adjust them for a specific funding scenario or reality since the parameters for continuation were not defined.

A copy of the evaluation schedule with a list of people contacted is included in Annex 4, while a list of documents reviewed is in Annex 5.

Assessment of Results and Impact of MCN/IC

Summary of Results by Indicator

All of this project's objectives were achieved or nearly achieved, and most of them were surpassed. Survey data that were collected throughout the project area indicate that project achieved significant impact within a very short time. There were significant changes in the adoption of preventive behaviors such as family planning, management of diarrhea with oral rehydration solution (ORS), immediate and exclusive breast feeding, and use of iodized salt. There were also changes in health status such as hemoglobin and urinary iodine levels, and in the proportion of malnourished children. The implementation of the community health program, which has been going for the past 2.5 years, is the primary variable that would explain these changes.

A complete table of all the project indicators and results from the baseline, final, and (Lot Quality Assurance Sample (LQAS) surveys is included in Annex 1 . The table below highlights some of the most dramatic results.

Indicator	**2001**	**2004**
% children 0-6 months who were immediately and exclusively breast fed	**72% / 58.5%**	**90.5% / 81%**
% of children <5 who are underweight	**35%**	**23.1%**
% of HH with iodized salt **Children 6-12 with urinary iod.>30**	**2.5% (GoT '2000)** **46.7%**	**77.3%** **69.3%** **(Pg wom. 75.8%)**
% of children receiving at least one course of worm medicine	**0%**	**92.3%**
% of women reporting use of modern contraceptive method	**38% (88.6%IUD)**	**45.1% (74.9%IUD)**
% of children receiving extra liquids during illness	**22%**	**69.6%**

Indicator	2001	2004
% of mothers citing condoms as a way to prevent STI infection	17.9%	40.8%

Overall Project Strategy

This project had an integrated approach emphasizing the development of community volunteers and training primary health care staff in the new behaviors and case management. Its primary partners were the Department of Health (DOH) for support of health service delivery and MSDSP for coordination of community activities and distribution of iodized salt.

The project began by developing a Behavior Change Communication (BCC) strategy. A consultant was hired and formative research was done to define messages, identify common channels for receiving information, and provide the basis for a comprehensive strategy. The BCC effort informed the rest of the project activities at both the community and health center levels.

At the community level, the project began by linking with the women's groups that were sub-committees of the Village Organizations that had been established by MSDSP. They trained the 300 "heads" of these groups in growth monitoring and nutrition promotion including breast feeding and complementary feeding. Subsequently, they selected and trained 80 community health promoters (CHPs) who had a wider range of knowledge (covering all the interventions) and had more regular training and supervision. With the support of the midterm evaluation recommendations, the CHP program was expanded from three to seven districts during the past year for a total of 160 trained CHPs. The project still has not determined how many CHPs are actually needed to cover each district.

Complementing the community activities, primary health care (PHC) centers were also strengthened. PHC staff were trained in the essential messages. 123 out of the 193 health centers were rehabilitated using a rationalized approach. (Each Chief Medical Officer submitted a list of PHC facilities that needed rehabilitation. This list was then submitted to the Head of the Department of Health for approval. RHCS applied the expectation that only PHC facilities > 5 km apart would be renovated (bearing in mind terrain) and that Village Organisations participate through the provision of volunteer man-power to help carry out the renovations) The Rational Pharmacy Policy and Management (RPPM) project assured the availability of affordable essential drugs. By including strategies at both levels, the population got consistent messages from their health services and the community volunteers. It also improved case management for diarrhea and acute respiratory infection (ARI) at the facility level.

Results by Intervention

All of the project interventions were technically sound, adapted appropriately to the local situation, and effective. There was good use of technical assistance which contributed significantly to the strength of these interventions.

Nutrition and Growth Monitoring (including breastfeeding and micronutrients) (57% total)

Malnutrition as well as micronutrient deficiencies were identified as priority problems during the early needs assessments in the target areas. The project addressed this concern by developing an integrated approach to health education and behavior change around growth monitoring activities. They used Trials in Improved Practices (TIPS) research to identify interventions for malnutrition and complementary feeding, developed messages for immediate and exclusive breast feeding, and mobilized communities for immunizations, micronutrient consumption, and use of iodized salt. In addition to identifying faltering children for case management at the PHC center, growth monitoring was used as a forum for conveying these messages to mothers of children under three. The Heads of Women's Groups from the Village Organizations were trained in growth monitoring promotion, they worked with PHC staff to develop a growth monitoring program associated with every PHC center, and they kept registers to track the weights of all the children under three in their communities. Weight faltering children from vulnerable families were refered to VO's for financial assistance if medical treatment or food aid were necessary .

Activities

- 300 Heads of Women's groups were trained as growth monitoring promoters (GMPs), refreshed once/year and supervised quarterly.
- PHC staff, MSDSP staff, and staff of local hospitals and polyclinics were also trained in growth monitoring in order to support the program and practice appropriate management of faltering children.
- Protocols are used for case management of children whose growth curves were falling or flat. These include assessing whether a child is otherwise sick, assessing feeding practices, offering advice on appropriate feeding, and treating with worm medicine.
- TIPS research and intervention provided the basis for strong and focused messages, increased the profile of interventions for nutrition
- Education materials were developed and printed for both parents and providers emphasizing appropriate feeding and case management messages. There is a strong emphasis on immediate and exclusive breast feeding.
- CHPs contribute to health education on the same topics.
- Micronutrient distribution is done twice/year on a campaign model. Iron/Folic Acid, Vitamin A, Vitamin D, (and historically lipyiodol) are distributed. Worm treatment was also recently added. Ferrous sulfate/Folic Acid is also distributed pre and post partum, and Vitamin A is distributed post partum within 40 days. AKF assures availability of micronutrients and anti-helminths while community volunteers identify and mobilize target children and health staff administer the medicines.

- Promotion, packaging, and distribution of affordable iodized salt at the community level is done through MSDSP distribution to Village Organization (VO) chairmen who sell it in the community on a cost recovery basis.

Strengths

- GBAO-wide availability of growth monitoring cards with mothers went from 0 in 2001 to 71.8% in 2004
- PHC staff, District staff, representatives of MSDSP, and HWG volunteers (VO members) were all trained in GMP leading to wide involvement with the program.
- Excellent consultants in the TIPS approach and in micronutrient supplementation were brought in to focus the essential nutrition behaviors and to technically strengthen the intervention.

Challenges

- Severe to moderate anemia in married non-pregnant women decreased from 20.3%in 1998 to 16.4% in 2004. (These results are still tentative as previous surveys used different methods for measuring anemia.)
- There is a lack of clarity between CHP and GMP roles and how to maximize collaboration at the community level. (addressed further in section on CHPs)

MSDSP AND DISTRIBUTION OF IODIZED SALT

MSDSP is a local NGO under the Aga Khan Development Network that has taken on responsibility for distribution of iodized salt. They procure iodized salt from a factory in Dushanbe, transport it to Khorog and distribute it to VO chairmen for sale at the community level. The cost is fully recovered including transport costs and a commission for the VO chairmen. Village volunteers and promote the use of iodized salt, thus creating the market demand. The price tends to be lower than that provided by local businessmen which may not be iodized, and iodized salt is available in most villages. (all those that were visited by the evaluation had iodized salt) Mothers knew to look for labels that indicated iodinization, 77% of households reported availability of iodized salt during the survey and urinary iodine levels increased since the baseline.

In Khorog Town the salt is sold through two distribution points. These points then function as wholesalers, with purchasers reselling the salt at a higher price in the market.

Challenges

- Adequate availability from the factory due to logistics constraints (fuel, etc.)
- A few problems with villages recovering the money to renew their supply. There tends to be limited transparency or controls on the VO chairmen's activities.
- There are only two distribution points in Khorog. There is a tendency for people to increase the price above the fixed price.

Recommendations
- Encourage (test?) free market distribution system in Khorog – build demand, increase consumer knowledge, and increase distribution points. (competition should keep the price down)
- See community partnerships for improving accountability of the VO in salt distribution

Immunizations (7%)

For this intervention, the project provided support for DOH efforts which included significant support for a recent national measles campaign. During this campaign the GBAO achieved the highest coverage in the coverage (estimated at 99%). Vaccines are offered at each PHC center on a monthly basis with PHC staff using cold boxes to bring vaccine from the District centers.

Activities
- CHPs, GMPs, and PHC staff were trained in the immunization schedule. CHPs mobilize and track target children in their communities, working with PHC staff to identify and mobilize defaulters. Coverage is generally very high (ranging from 62% with measles to 85% with 3 DPT vaccines) However, there has not been significant change in coverage since the project. This may be explained by the shift in focus in 2004 to measuring coverage in children < 12 months.
- Support for vaccine distribution through provision of fuel to the District and logistic management between Dushanbe and the Oblast.

Challenges
- DOH still depends on monthly immunization days with retrieval of vaccine in cold boxes by health posts and local hospitals. Vaccine retrieval may be difficult, although local government council has a budget to help with transport even if they are not often forthcoming with the money.
- There is reluctance to waste vaccine by opening vials if there aren't enough children present. This seems to be a particular problem for BCG.

Acute Respiratory Illness and Control of Diarrhea Disease (14% total)

These two interventions are combined in this report because the strategies and activities have essentially been the same for both. PHC staff were trained in case management for both diarrhea and ARI. In communities level, home management of diarrhea with oral rehydration solution and recognitions and referral for danger signs level, while home management for diarrhea including distribution of ORS, the importance of increased feeding and fluids, and recognition and referral of danger signs were taught at the household level.

Activities
- CHPs were trained to advise mothers on use of ORS for diarrhea, recognition and referral for danger signs, management of fever, and the importance of increased

feeding and fluids for sick children. The survey indicates mothers are learning and practicing these messages.
- CHPs provide ORS at the community level
- Complementing efforts through the RPPM project assured the availability pf essential drugs at the PHC level and decreased the use of antibiotics by trained PHC personnel.

CHPs provide education on hygiene and diarrhea prevention, including organization of community efforts to build toilets

Challenges
- Training and messages are still intervention-specific and vertical in this project. The IMCI approach is lagging in both the national and project approach to these interventions.

Family Planning (7%)

Activities
- CHPs and PHC staff promote a variety of family planning methods (condoms, spermicides, pills, IUDs, injections) There was a significant increase both in the choice of methods and in women's awareness of different methods. The survey indicated that family planning use increased, while IUD use, which has traditionally been the method of choice, decreased. There was a concurrent increase by 10% of women choosing to use oral contraceptive pills or depo-provera. People report that husbands and mothers-in-law generally support FP use.
- 10 midwives were trained in IUD insertion. Equipment was provided for IUD insertion and SM activities even in medpoints that don't yet have the personnel to do these activities with the idea that doctors doing supervisory visits could offer IUD insertion as part of their visit.
- Youth and youth groups are targeted by some CHPs with FP and HIV prevention messages – regardless of marital status or gender.

Challenges
- Options for a reliable supply of contraceptives are still not clear. At the moment, free contraceptives are available from UNFPA, although there is some concern about whether this is reliable in the long term. Meanwhile, these supplies tend to undermine both coverage and willingness to pay since women may postpone getting supplies in the hopes of eventually getting them free. They also put the RPPM project in a bind because they have a supply of contraceptives for sale which could expire in the face of the free UNFPA supplies..
- 5% of women still report having an abortion within the past 5 years
- With government regulations that only trained doctors or certified midwives can insert IUDs, there is limited access to this (preferred) method in rural areas. This has been addressed in Roshtkala District by having the supervising doctor insert IUDs in rural PHC centers while she is visiting.

Reproductive Health / HIV Prevention (7%)

Activities

- 9 people in Almaty were trained in the epidemiology of HIV/AIDS and 31 people in Dushanbe were trained in counseling and testing for HIV. The project provided 5,500 rapid test kits to the Oblast.
- PHC staff were trained in syndromic diagnosis and treatment of STIs. The RPPM project assures the availability of the essential drugs for case management.
- CHPs are distributing condoms and providing health education on HIV and STI prevention in their communities. They particularly target youth and men leaving for Moscow.
- 1000 'Goody Bags' containing 30 condoms, brochures on HIV/AIDS and STIs and toiletry articles were distributed through CHPs for distribution within their communities to people who were migrating outside Tajikistan for employment.
- 1000 Drivers Manuals distributed to drivers containing in addition to rules on driving, information about HIV/AIDs and STIs.
- Health fairs on HIV/AIDS organised in Khorog, Vanj, Darvaz, Rushan and Rostkala Districts.
- Provided financial assistance for delivery of blood samples to Almaty for confirmatory testing of HIV/AIDS.

Challenges

- There is low awareness in the Districts that the test is available. (or low willingness to acknowledge the test's availability?) This is probably exacerbated by history when being diagnosed with an STI was punished.

Maternal Newborn Health (7%)

Activities

- 48 midwives were trained in safe delivery
- AKHS is working on hospital care at the tertiary level in the Oblast and most Districts.
- Equipment, including safe motherhood equipment, was provided to the PHC centers in preparation for a more comprehensive safe motherhood intervention. Other components that are in place include women's attendance at pre-natal care, deliveries and post-natal care by trained attendants – albeit at home, and the organization of emergency fuel for transport organized through most village organizations.

Challenges

- This intervention was not addressed in a comprehensive way. 7% level of effort is inadequate to make a real difference in maternal health and the project did not have the time or resources to devote more. With the midterm evaluation recommendation to focus on strengthening the CHP approach rather than adding the remaining interventions, this effort was consciously left limited.

Recommendations for Technical Interventions

In general these were very strong interventions, both technically and in the quality of their implementation. As a result, the recommendations are relatively less significant than those for the subsequent sections. However, these recommendations were developed by the team as suggestions for improving some of the challenges that were identified.

- Advocate with MOH to allow trained and certified nurses (in addition to doctors and midwives) insert IUDs to improve access.
- AKF and DOH should send a joint letter to Unicef requesting vials with fewer BCG doses.
- Depending on the availability of funding, a safe motherhood initiative also including newborn care should be undertaken.
- Continue to work with the Centers to encourage implementation of IMCI as well as Community IMCI (an integrated approach at the community level) to better integrate training and program implementation.
- Continue to work on implementing HIV testing including promotion throughout the districts of its availability.
- Strengthen micronutrient distribution for provision as part of routine care:
  - Integrate micronutrient distribution with routine services
  - Assure supply either through the RPPM or the ORS/condoms distribution networks.
  - Integrate monitoring with other PHC monitoring

Cross-Cutting Approaches

Behavior Change Communication

The project invested resources, including hiring of a BCC consultant at the beginning of the project, to clearly define project messages and develop a comprehensive strategy which employed multiple channels for message transmission. In addition, a situation analysis identifying barriers and enhancers for behavior adoption was completed as part of the formative research. The BCC strategy covered all corners of the region

The primary tool used by the project for message transmission was a set of brochures in Russian and Tajik languages covering all the interventions. Several of these were also printed in the Kyrgyz language. Because the target population was largely literate and starved for reading material, these were very popular and effective. The brochures were supplemented by TV and radio spots which were aired in Khorog and distributed as tapes to the Districts; home visits for education and follow up; and health education sessions which were both specially organized and also took advantage of other events such as weddings, parent meetings, village organization meetings, and funerals.

A final element of the strategy was the strengthening of the Center for Healthy Lifestyle (CHLS), particularly at the Oblast level. This is a government unit that is considered one of the District Centers, although its function is to assist with development of messages and materials for health prevention and behavior change. The project provided both

training and equipment to the head of this unit. Unfortunately, while the consultant didn't have time to explore the function of this unit in depth and acknowledges that it has only really been functional for 8 months, it appeared to her that collaboration between this unit and the Centers was limited, and that its ability to deliver the expected results without additional project support was also limited. She also noted that while there is allegedly a CHLS unit at each District level, its representatives did not appear integral either to project function or to community level support. None of the District Monitors in the Districts that were visited were drawn from the CHLS at the District level.

The BCC approach in Khorog town used the same messages and strategies as the more rural areas. However, it was clear in talking to some of the Khorog CHPs that while they and their communities appreciated the information they had learned, there was a significant demand for additional information. Specifically, they requested information on a variety of new topics such as alcoholism, drug abuse, disabilities, care of the elderly, and suicide.

Challenges

- It is unclear to the consultant, what, if any, role the CHLS should continue to have in project interventions.

Recommendations

- Carry out a needs assessment in Khorog town to determine priority health information needs.

Lessons Learned:

- In a literate society, use of brochures and emphasis on data are both feasible and effective.
- CHPs and health workers agreed that group gatherings were the most effective way to do health education.

Community Health Promoters

The establishment of a strong community volunteer program with good training and support was the primary basis for this project's success in achieving behavior change at the household level. This entailed both the GMP volunteers outlined in the section on nutrition, and the Community Health Promoters (CHPs). Growth Monitoring Promoters preceded the establishment of the CHPs, were selected from the Heads of the Women's groups from the VOs, and were trained to help with growth monitoring and track children who were faltering. PHC staff, MSDSP representatives and local hospital and polyclinic staff were trained at the same time to provide consistency to the effort. The CHPs complemented the activities of the growth monitoring promoters in villages where there were both, although there was some confusion with their respective roles.

The CHP intervention was piloted initially in three districts and Khorog town. At the recommendation of the midterm evaluation, the effort was extended during the past year to the remaining four districts. CHPs were selected by the community and provided five

days initial training in all of the interventions. They were extremely well trained with the ability to explain the full range of messages: breast feeding, HIV prevention, family planning, complementary feeding, diarrhea treatment, ARI management, and immunization schedules, etc. Both newer and older CHPs seemed to have similar knowledge levels. Their tasks were to provide health education, do home visits, mobilize for micronutrient distribution and immunizations, distribute condoms and ORS, and maintain population-based registers which provide the basis for tracking and follow up of pregnant women, women using family planning, children lacking immunizations, and children who were growth faltering or needed weighing. They also provide a two-way link between the population and their health services with PHC staff acknowledging how much the CHPs help them do their job. The program was well developed, with documentation on selection criteria, job description, training materials, supervision check lists, and refresher training.

The CHPs were enthusiastic about their jobs, indicating that they felt important, appreciated by their communities, and that they appreciated the access to new knowledge and regular monitoring that the project offered. Most indicated that the knowledge and the opportunity to serve their communities were significant motivators. They did not mention incentives as a concern, although the training perdiem ($ 4US/day to cover food and accomodation costs) and boots/jackets that the project offered were probably not insignificant. Attrition has been relatively low (<10%) with all attrition coming from the early districts and the majority from Khorog town. The cause for all of the attrition was that volunteers moved away (e.g. to Moscow or got married).

CHPs are supervised quarterly by District Monitors and the RHCS CHP Program Officer, and receive refresher training every two months. Both Oblast and District staff are trained as trainers, and a detailed supervision check list provides guidance to assure comprehensive supervision.

While the situation in Khorog town is somewhat different, the role of the CHP was still working well. The CHPs indicated that they served their block as their community, that people on their block appreciated their services, and that they provide a significant link between people and their health services. It is interesting to note that these CHPs tended to be a little better educated, and they saw their efforts as a way to help their Imam as they themselves had been helped during the early nineties. They indicated that their primary support people were AKF staff and one of their trainers, but that there was no District Monitor system for their supervision.

Challenges

- Support for all aspects of the CHP program still depends largely on AKF. The supervision and training perdiems mean AKF pays DOH staff more than the DOH itself and they are seen as the force that motivates and drives activities in the districts.
    - There is no plan at the district level for incorporating CHPs or GMPs in district budgets and work plans. Acknowledging that it is costly to train, supervise, and support a large number of volunteers, a common vision for

the level of coverage and support for community volunteers in a district is missing. There is confusion and overlap between the CHP and the GMP roles.

- The linkage between PHC staff and CHPs is informal. PHC staff were trained in the preventive messages, but not oriented towards supporting CHPs.
- Supplies tend to come directly from AKF, and reports are submitted directly to AKF.
- CHPs and GMPs require regular ongoing support and training to maintain their activities and enthusiasm.
- There is no support structure for CHPs in Khorog town.
- There is no systematic structure for identifying and orienting new volunteers in case of attrition

CHPs in Murghab District

And Ishkashim District

Partnership with DOH

While the project made an effort to work with the DOH in training and supervision, it lacked an overall vision for gradually decreasing its responsibility relative to the DOH. As mentioned previously, AKF had a tendency to take responsibility for project activities at all levels, never holding the DOH accountable for the aspects it could have been responsible for. This gave DOH an excuse to consistently defer to AKFs resources and project ownership.

This said, there were several positive strategies that the project adopted with respect to its DOH partner. In particular, the project developed the position of District Monitor to strengthen supervision of PHC and community level activities. They advocated for selection of competent people by the District Doctors, trained them, and supported their supervision activities with fuel, supervision check lists, per diem, and technical assistance. The Monitors were also trained as trainers for CHPs and PHC staff. There are a total of 16 District Monitors, with most districts having 2-4 who are responsible for monitoring general PHC activities, CHPs, GMPs and pharmaceuticals. They are well trained and generally enthusiastic about their role, feeling they make a difference. They appreciate both the resources and the knowledge the project has given them to do their job, describing isolation as one of the main constraints the project had addressed. While the project had established this as a new role, there was no discussion raised by DOH staff during the evaluation to question its validity or importance.

The project also strengthened PHC services to complement those in the community. Between MSDSP and the two health projects, a total of 123 out of 193 PHC centers (medpoints and ambulatories) were rehabilitated and equipped. The project had access to an engineer to help with this work, and the construction was well done. It also emphasized training of PHC staff with the same messages and content as the community volunteers. This assured consistency between the different service providers and also improved case management at the health center level (e.g. emphasis on exclusive breast feeding, ORS treatment for diarrhea, and complementary feeding for growth faltering). PHC and District staff were also trained in management. Research subsequent to the evaluation indicated that utilization of these services generally increased after rehabilitation. However, there were decreases in utilization in nearly half of the health centers. The data therefore suggest significant variation between centers and probably suggest the need for further inquiry regarding impact of the rehabilitation, the causes for the inconsistency, and ways to improve the effort.

Community members who were interviewed generally reported satisfaction with their health services. They indicated the providers try to help when they can, they make home visits when necessary and are available anytime, they do not add extra charges for their services, and that drugs were generally available.

Finally, the project made a sincere effort to work with its partners on data generation and use. An attempt was made (which stuck in some districts) to have regular quarterly

meetings to review reports and discuss activities. District staff were trained in Lot Quality Assurance Sampling (LQAS) monitoring, and were able to discuss the process they followed during the last LQAS survey in August. More significantly, they were able to discuss the results and implications for their particular districts.

Challenges

- The biggest challenge for this project is that responsibility and accountability for its activities are not truly shared with its partners. The project recognizes (rightly so) that it can generally complete the activities better than its partner and so has the tendency to step in and do so at the expense of building the capacity and responsibility of the DOH. These problems are clearly exacerbated by the low salaries and high turnover within the DOH.
- Separate from but related to the previous point, key government and decision makers in some districts and at the region may not be aware of the real benefits accruing from CHP activities or of the useful information they are generating. This may even extend to within AKF / AKHS itself and MSDSP.
- Training for staff in local hospitals and polyclinics slipped between the AKHS activities (which focused on regional and district hospitals) and RHCS (which focused on PHC centers). As a result, these service centers receive CHP referrals, but still treat based on old practices.

Recommendations – CHPs/Community Volunteers and DOH Partnership

Given that the DOH partnership and support for the community volunteer program were seen as the weakest areas in the project design and implementation, these are the focus for the most important recommendations. These recommendations would also be relevant when refining the CHP model for implementation elsewhere.

- Supervision and support structures need to be reinforced to increase the ownership of and responsibility for the community and PHC program by DOH counterparts:
    - The CHP and GMP roles should be combined into one person who will be responsible for both sets of activities. AKF should negotiate with each district for an adequate but affordable number of CHPs for coverage (a rationalized approach to CHP coverage)
    - The PHC centers should be increasingly responsible for both routine monitoring and refresher training of the community volunteers. They (possibly along with VO representatives) will need to be included in all training activities to encourage this effort. They will also need training in training methods (participatory adult learning)
    - The CHP reporting system should go through the PHC centers to the District Monitor and the Chief Doctor. AKF may receive reports from the District Monitors, since this should be their primary point of collaboration.
    - A CHP supply system through District Monitors and PHC staff should be strengthened. (condoms, brochures, ORS (and micronutrients? And IUDs?)).

  - If possible, the program centers should be more involved with supporting refresher training. They should also be encouraged to collaborate more among each other and with the Districts.
  - For Khorog Town, the link between the CHPs and their VOs for community mobilization should be reinforced, but the link between CHPs and the department Centers for technical support and reporting should also be developed.
- During the next phase, an effort should be made to include local hospitals and the Polyclinic in training on new messages to assure consistent messages and practices between health service providers and community volunteers.
- The project may need to "market" the benefit of CHPs to higher level decision makers both within the organization and in government to assure their inclusion in planning and budget.

Lessons Learned

- PHC and health provider staff need the same training as community staff to assure consistent practices as well as to encourage their collaboration with and support of community activities.
- Access to new knowledge and strong monitoring support may be the most important elements for motivation and quality at both community and facility levels.

Partnerships – Community Level

As mentioned in previous sections, there are three health-related structures at the community level: CHPs, GMPs, and health committees which are part of the village organizations that were developed by MSDSP. These are complemented by the local government which has a budget for health, but may not offer those funds unless asked. Because the Heads of the Women's Groups were selected as GMPs, and because they were trained with their respective medpoint staff, they tended to be better linked with both the VO and the health services. While the CHPs were very well trained and active in a wider variety of health interventions, their linkages were more informal. They were not necessarily VO members, and the amount of support they got from the medpoints varied with the specific relationships.

The role of the health committee in the VO was the least defined of these three cadres. The VO was established to be responsible for general development activities. They generate funds through membership dues, and use these funds for a variety of activities including subsidies for health care and food for people who can't afford them. They were involved with oversight for the health center rehabilitation activities, and provide a forum for monthly discussion of health concerns. However, the health committees have had not training, tend to be small and limited to health center staff, and do not have any role in oversight or advocacy for health services.

Challenge:

- There are significant community structures whose potential for linkage, synchronicity, and mutual support have been underutilized.

Recommendations – Community Partnerships:

- Strengthen the vision that the VO / health committee, CHP and med-point staff work as one team to improve health in the community.
- Continue coordination efforts with MSDSP to integrate community volunteer activities with those of the health committees.
  - Encourage the VO (health committee?) to review salt distribution responsibilities and controls.
  - Involve the VO in med-point oversight and financial accountability, including making the local government budget more transparent.
  - May need to expand and strengthen health committee.
  - Discuss the possibility of including PHC staff in MSDSP trainings on management and statistics

Training

Training is another example, like the BCC strategy, where the project thoughtfully developed a quality approach to its implementation. 30 project and DOH staff were trained in adult participatory learning approaches, and all the training materials were developed using these approaches.

The project provided extensive training to everyone: 492 doctors, 3395 mid-level personnel, 22 pharmacists, 160 CHPs and 300 GMPs. Trained PHC staff were able to describe appropriate case management for growth faltering, diarrhea, and ARI. The CHPs were generally very enthusiastic in their description of all the messages and knowledge they had learned.

Challenges

- With a lot of the training covering one topic at a time, there were situations where different people received different aspects of the training due to rotation of the opportunity for attendance. This was a challenge for achieving consistent training across all the interventions as well as for achieving an integrated approach to the health interventions and case management.
- AKF staff feel PHC and volunteer counseling skills are still weak

Recommendation:

- Develop counseling as an integrated component with all training topics.
- See technical recommendations for implementation of IMCI.

Sustainability Strategy

The DIP outlined ideas for sustainability indicators as part of the original project design. However, these did not seem to have been internalized by project staff and they did not hold themselves to a sustainability plan. The suggested indicators included:

- M&E teams in place and functioning
- Development of DOH trainers
- DOH staff and partnerships established at the community level

- Completion of an organizational development plan

In spite of the lack of a plan for gradually decreasing inputs and phasing project activities over to partners, there are program elements where progress towards sustainability has been achieved:

- There are considerable changes in knowledge and behaviors at the household level.
- Iodized salt is distributed throughout the region with nearly full cost recovery.
- Well-trained district staff are functioning as trainers and supervisors for preventive activities, although these activities are still fully dependent on AKF's financial and technical support.
- There is an increasing community awareness of and demand for services such as FP, immunizations, and GM. This puts pressure on the PHC centers to maintain these services.
- PHC staff and community volunteers are well trained and capable of continuing the interventions at the community levels. PHC staff indicate that immunizations and growth monitoring are part of their job whether or not AKF is there.

As outlined in the previous sections, AKF had the tendency to bypass government structures to support their community level activities because they could assure them more reliably and efficiently. There was little evidence of phasing down AKF inputs and activities, of holding the DOH accountable for their agreements, or of increasing the DOH responsibility for some of the activities. While it is unrealistic to talk about program sustainability within the 2-3 years that this project was functioning effectively, not enough attention was paid to the phase-over increments that might have been achievable.

This lack of a sustainability orientation was exacerbated by the lack of recognition at both the partner and AKF field staff levels that the resources are finite. People have a tendency to see His Highness as the primary source of vision and money. These people don't really believe that resources will be cut off if the program is going well because he will find the money somewhere. If this is the case for AKF field staff, it is even more difficult to convince DOH or community counterparts that the resources are only for the short-term.

The recommendations outlined in the partnership sections which emphasize strengthening the links and accountability between the community and PHC levels as well as formalizing the DOH supervision and reporting structure should help contribute to the sustainability of a community component in the future.

Program Management

The management of this project was inconsistent. While the program was technically strong with good technical assistance that contributed to local capacity building, there were problems with financial management and consistent staffing. Organizational capacity building approaches were planned in the DIP for AKF in Washington and the field, but these were not implemented.

Unlike the previous sections, the following conclusions and lessons learned are a reflection of conversations the evaluator had with AKF personnel, and do not reflect the work of the team as a whole.

Planning

Terri Lukas in the AKF Washington office was instrumental in developing the detailed implementation plan with participation from field staff and DOH partners. However, the ability to do long term planning was distinctly limited by staff turnover both in AKF Tajikistan, and in the DOH. As a result, at the time of the evaluation, no one was in the office who had been there during the first two years of the matching grant (1998 – 2000) or the planning phases of the child survival project. The tendency of the organization towards vertical management also meant that the field staff, whose tenure may have been longer than that of senior management, had not been involved with long term planning for the project, nor were their planning skills reinforced. These staff identified their own weakness in planning capacity. It should be noted that the Health Sector Reform project has focused on capacity building for planning and rationalizing health services with the DOH partners. However, these skills or capacity building were not directly applied to child survival implementation.

Staff Training

The main staff development activities took place through the employment of excellent technical assistance. Consultants shared expertise on TIPS, micronutrients, monitoring and evaluation, and LQAS. These led to significant learning on the part of staff and improved quality in the programming, although staff did not view these visits as training. Senior staff, both ex-patriate and national, also spent time strengthening mid-level staff skills such as budget management, data analysis, and community mobilization such as for the CHP program. In terms of formal training, the following training took place:

- HIV/AIDS prevention and counseling - staff and DOH partners were sent for training (Almaty and Dushanbe)
- Community based social mobilization - trainers came from Karachi to Khorog
- Nutrition for Infants, Young Children and Pregnant Women - WHO recommended trainers came from Eastern Europe to Khorog
- IMCI training – staff and partners were sent to in Dushanbe.
- Ongoing training in English which significantly facilitated the evaluation, among other benefits.

Given that most of the staff were doctors whose only experience was hospital-based, it is clear that a lot of capacity building has indeed occurred over the course of this project. Mid-level staff have an understanding of public health and up to date technical interventions, and their skills in reporting and problem solving are improving. There has been a lot of capacity exchange among the mid-level staff with significant learning occurring from their supervisors. However, some of the analysis and management skills, particularly with respect to financial management, are still lagging and there was no systematic assessment of staff needs for development and training to identify and address these.

Supervision of Program Staff / Human Resources Management

In general, the staff have a great sense of team work, morale is good, and there is a lot of cooperation and sharing of responsibility among them. Within their respective projects, the Project Managers seem to effectively manage and support their staff. However, a general problem was identified with the organizational structure. It was widely that the posting of the Health Program Manager in Dushanbe is essential for representation, contributing to advocacy and policy development, and increasing the awareness of AKF innovations outside of the GBAO. However, it leaves something of a management and administrative gap in Khorog. There is little formal coordination between the different health projects, and it means that any significant financial and program approvals are dependent on communications between Khorog and Dushanbe.

Financial Management

This is the management area experiencing the most difficulties. The project budget was consistently under spent, project managers indicated they never knew how much money they had to spend, there was confusion over which charges were being expensed to which health project, and the mid and lower level staff had countless complaints about the approval and reconciliation systems for spending money at the field level. While it was difficult to get a clear understanding of where the problems are since there are two sides to every complaint, the following observations may contribute:

- In the earlier years of the project, financial management was much more centralized in Dushanbe. This may have included some financial decision making as well as an assumption that the project managers were not capable of managing their budgets according to all the financial regulations of the donors. Managers reported that it was difficult for them to get their budget balances out of the financial office.
- There has been an increasing effort over the last year or two to put financial information in the hands of the managers. The finance office reports being open to problem-solving finance difficulties, and the consultant found them helpful in obtaining the financial information she needed to assess spending. However, this shift has required a lot of training and capacity building in financial management since those skills were not previously developed. Progress had been made at the senior level, but the lower levels still have little understanding of either the budget or the financial systems.
- Project staff still don't have the capacity to understand and effectively manage their budgets within the regulations of their grants. This is particularly true of mid-level staff who end up bearing the burden of managing cash advances and accounting. These staff report spending up to 50% of their time managing money (e.g. training advances)
- Particularly mid-level staff feel there are excessive limitations and controls on getting and accounting for money. Contributing to this are the lack of a manager for finance approvals in Khorog, a lack of orientation of mid-level staff to policies and procedures (they don't understand them), and a lack of transparency regarding how some of the policies were determined. Everyone acknowledged that lack of planning ahead probably also contributes to the difficulties.

These problems, particularly the lack of access by project managers to their budget balances, probably significantly contributed to the under-spending of the budget. Project staff told stories about having financial staff tell them they couldn't do program activities they were planning because they didn't have the money. While this may have been due to line item allocation, it gave staff the sense that they didn't have enough money to do their project. The already slow spending was compounded by the slow project start explained at the beginning of this report, and the weather which limits the ability to mount large scale activities throughout the year. Finally, the project has been running at its full level during the past two years, and the spending rate went up accordingly. It is unfortunate that there is no opportunity for a no-cost extension so the project could complete the IMCI training for PHC staff at the district level (to complement the IMCI training received by the district monitors and RHCS staff in November 2004) and safe motherhood training. These were planned for, but which there was inadequate time to complete them.

Information Management

The project had a relatively effective M&E system in place which depended on entry and analysis of supervision check lists and annual LQAS monitoring surveys. This was refined by a consultant who developed the reporting forms and reviewed the indicators against the project plan. The strength of this system is that the supervision check lists serve as a tool for strengthening project quality and management, and for providing feedback on process indicators. Meanwhile, the LQAS offers a relatively inexpensive tool (the last round cost $900 including full participation of partners in analysis) to monitor project results indicators. These methods provide an alternative to routine monthly activity reports which tend to yield counting data that may not reflect actual project progress.

Both project and DOH staff are able to independently carry out and analyze their LQAS surveys getting direct feedback on some of their impact indicators. District Monitors were able to explain the LQAS results as they pertained to their districts, and had an understanding of the implications for management. AKF staff felt the LQAS offered more program-specific information and feedback and was therefore more immediately useful than their bigger survey.

At the PHC and community level, there are a series of registers used for tracking. A lot of information is contained in these registers, and some of it is used by people to track and follow up on immunization defaulters, potential family planning users, growth falterers, etc. The PHC registers are very numerous (as many as eleven in one PHC center that was checked) but have been defined by the DOH and are therefore not very negotiable. The advantage is that they are integrated with the DOH information system. The registers at the community level are consistent with the PHC registers and can therefore contribute to the DOH system. Unfortunately, the ability of PHC and community people to maximize the use of the information in the registers, particularly for tracking trends and identifying problems, is still limited.

There are two gaps in the project information system. One is that utilization data are not used at all as an indicator for quality or change in community demand. These are collected monthly by the PHC centers and submitted to the Districts, but the project neither accesses nor uses them. In the future, this is an easy source of data to assist with monitoring. Secondly, while the supervision check list data are entered and a report can be generated, there is too much data to be useful and the staff are not clear how to analyze it or pick out the most useful information. Therefore, this report is underutilized. More work with staff on analyzing and using the information, and/or simplifying it further would make it more useful. However, this is probably secondary since it is the end of the project and it is unlikely that this level of detail in supervision will be maintained.

Recommendation:
Train PHC staff and CHPs to use their own data (registers and utilization data) to track trends and progress. (e.g. review utilization data, morbidity trends, family planning users, skilled deliveries, etc.)

Logistics

In spite of geographic constraints, procurement seemed to work pretty well between Dushanbe and Khorog. The project generally had the supplies and equipment it needed, and there were no apparent delays due to procurement problems. Unfortunately, up to now the supply systems between Khorog and the districts are still dependent on project vehicles and fuel. This is discussed in the section on CHPs, and will need to be addressed through the DOH if supplies are to be maintained at the PHC and community level.

Technical and Administrative Support

The technical assistance provided for this project was a real strength. It was relevant, appropriate, increased the capacity of the national staff, and assured the quality of the technical interventions. The TA set the direction for the main project interventions and activities, making it possible for project staff to successfully implement them. Even though she wasn't a short-term consultant, the Communications Officer also played this kind of role in the project with respect to the community level and BCC activities.

The project also had excellent written resource materials provided by the AKF Washington office. The effectiveness of these materials was facilitated by the increasing ability of the staff to use English materials.

It was unfortunate that both Tajikistan and Washington expressed frustration with their technical support relationship. There seemed to be a lack of understanding regarding their respective roles in assuring the success of this project. There was a tendency in Tajikistan to see Washington as being demanding and micro-managing issues outside of their realm of responsibility, while Washington felt its help was unwelcome. As a result, the potential benefits of the backstopping relationship were not maximized.

Management Lessons Learned

There were several suggestions for improving management that might improve program effectiveness in the future:

- Minimize day to day dependency on communication and responses between Khorog and Dushanbe. Communications are unreliable, delegation in case of absence is sometimes confusing, and these lead to unnecessary project delays.
- Increase the capacity of project and mid-level staff in understanding and managing budgets. With increased understanding of the budget management process and its limitations they will be more likely to spend appropriately, comply with regulations and to understand why they need to plan ahead.
- Increase the transparency of management and financial decision making (e.g. salary scale, approval levels, etc.) in order to increase staff compliance with and appreciation for the policies.
- Particularly where donor expectations may be new or different (as is the case for centrally funded child survival grants), it is important to clarify the roles and responsibilities for assuring quality programs at the field level – distinguishing between management issues and technical support.
- Short (and longer) term technical assistance served as an excellent capacity building tool. Significant staff development and attitude change occurred under this guidance.
- M&E training or technical assistance is more effective when the trainer can walk staff through the whole process from data collection to analysis and use of the data. This was done with the LQAS training and staff felt it was a tool they could really use. Conversely, while the M&E consultant left a well developed system with all the necessary forms and data entry frameworks, the lack of guided experience in using the data left staff unsure about the analysis.

Conclusions and Recommendations

In general, this was an excellent project that managed to achieve significant impact under extremely difficult conditions. It pioneered the development of community health volunteers, integrated preventive messages at the community and PHC level, and trained a large number of people throughout this expansive region:

> At the household level, both knowledge and behaviors changed significantly in all the intervention areas. Mothers indicated they did not experience major barriers to adopting the new behaviors, and a well-conceived BCC approach support these changes. Mothers were familiar with and appreciated the services of their volunteers and PHC centers.
>
> At the community level, volunteers were enthusiastically and knowledgeably tracking health indicators in their communities. They were active carrying out health education sessions, doing home visits, mobilizing community members for growth monitoring, micronutrient distribution, and immunization; distributing condoms and ORS, and coordinating activities with their PHC staff. Iodized salt is

available in all communities through cost-recovering distribution by the village organizations.

PHC staff were also well-oriented in all the intervention areas. They were trained and knowledgeable in appropriate case management for malnutrition, ARI and diarrhea; and health centers were rehabilitated, equipped, and had essential drugs which were provided on a cost recovery basis through the RPPM project. As a result, people had confidence in the care they received.

District staff in some districts were aware of and appreciated the impact of the CHPs, District Monitors were well-trained and generally enthusiastic about their role in supporting the quality of both PHC and community activities.

This said, the greatest weakness of this project was its inability to maximize its partnerships and develop an effective phase-over plan. At this point, particularly since the project has really only had full momentum for 2.5 years, it would have been unrealistic to expect sustainability for most of the activities. However, without a vision for gradually decreasing AKF support while holding DOH accountable for a corresponding increase in their support, there is no "road map" for ever achieving sustainability. The partner relationships at the community level such as those with the village organizations and the PHC centers, which might also contribute to the potential for sustainability, were also underexploited.

A summary list of recommendations and lessons learned is included in Annex 2.

Results Highlight

Community Health Promoters

We sit down to finish the last CHP interview in the course of the final evaluation process. We are sitting outside because the thin winter sun is still warmer than the indoor temperature. I expect to hear a long list of things these CHPS had learned, to hear about their home visits and education sessions which reach mothers even in the most distant communities within this already distant and sparsely populated Oblast, and to hear about how much they appreciate the training this project has given them. I also expect to hear about how the mothers' appreciation for them contributes to their enthusiasm about the job. These are things I have been hearing for two weeks, and I have no reason to expect that this will be different.

As we start, I realize that the slight young woman we are talking with is shaking and her voice is trembling. I feel badly that she feels so afraid of me. However, as she gets going I suddenly realize that she isn't shaking for fear. She is shaking because she is so excited about everything she has learned and is doing. She speaks faster and faster and her eyes start to pop out with her enthusiasm as she describes how her mothers are now exclusively breast feeding their babies and these babies are fat and healthy, how she got all her mothers participating in the recent measles campaign, how much they all appreciate understanding different family planning methods and the choice they have for which they want to use, and how she helped them mix ORS when their children had diarrhea during the diarrhea season this summer. In the six months since she was trained she has mobilized the community to build two new toilets for preventing diarrhea, coordinated with the staff in her PHC center to assure coverage during the measles campaign, and her community comes to her first when their children get sick. Finally, when asked how she reaches the people in her community, she rattles off the list of all the places she has done her health education: village organization meetings, parent meetings at school, weddings, prayer meetings, funerals, youth groups, and home visits. She has truly understood what community mobilization and health education are all about.

As we get up to leave, (and as I write this) I am left with that sense in my heart that this is what this work is all about. I, personally, was touched by this woman's enthusiasm and how things have changed for her and her village as a result of what she learned from this project, and I am grateful for it.

My favorite CHP (right)

ANNEX 1 - SUMMARY TABLE OF INDICATORS FOR MCNIC GRANT

I. INCREASED CHILD CARETAKERS' KNOWLEDGE AND PRACTICE OF CHILD SURVIVAL INTERVENTION

Component/Objective/Indicator	Baseline				Final			
	Data source	**Sample size**	**Value**	**Comments**	**Data source**	**Sample size**	**Value**	**Comments**
Percent of children 0-23 months whose birth was attended by a skilled health professional (*20% increase*)	HNS 2001	1,169 (births in last five yrs)	76.4% Dr: 29.3% Feldsher: 9.2% Nurse: 17.9%	Value includes all children born within the last five years	HNS 2004	943 live births	*Skilled:* 76.1% (n=718) Doctor: 27.8% Nurse/feldsher: 22.8% Midwife: 25.6% *Unskilled:* 22.5% (n=213) Relative/friend:11.7% TBA: 10.8%	
	LQAS 2003	152 hhlds (19 per district)	90%		LQAS 2004	152 hhlds (19 per district)	90%	
Percent of children 0-6 months who were exclusively breastfed in the last 24 hrs (*20% increase*)	HNS 2001	1,565 children 4-59 months	58.5% started complementary feeding before 7 months	Questions on exclusive breastfeeding were misinterpreted	HNS 2004	116 children 0-6 months	81.0% (n=94)	

	Baseline				Final			
Percent of children 12-23 months who were vaccinated against 6 diseases before first birthday *(90% of children)*	HNS 2001	377 children	71.6%		HNS 2004	215 children with maternal report 150 children with valid facility card information	Received at least one dose: 69.3% (n=149) Ever received: 36.0% (n=54) Received before 12 months: 8.7% (n=13)	
					LQAS 2004	152 hhlds (19 per district)	80%	
Percent of children 12-23 months who received measles vaccine *(90% of children)*	HNS 2001	377 children	74.5%		HNS 2004	215 children with maternal report 150 children with valid facility card information	Received: 75.9% (n=163) Ever received: 62.7% (n=94) Received before 12 months: 20% (n=30)	
					LQAS 2004	152 hhlds (19 per district)	80%	
Percentage of children aged 0-23 months who received increased fluids and continued feeding during last illness	LQAS 2003	152 hhlds (19 per district)	20%		LQAS 2004	152 hhlds (19 per district)	75% more liquids 85% more food (breastfeed)	

	Baseline				Final			
(20% increase)					HNS 2004	467 children 0-23 months	*Received increased fluids and continued feeding*: Increased breastfeeding: 64.9% (n=303) Increased liquids:69.6% (n=325) Increased food: 37.3% (n=174)	
Percentage of mothers who recite at least two signs of childhood illness that indicate the need for treatment *(50% of mothers)*	LQAS 2003	152 hhlds (19 per district)	95%		LQAS 2004	152 hhlds (19 per district)	95%	
					HNS 2004	467 mothers of children 0-23 months	66.0% (n=308)	
Percentage of mothers of children 0-23 months who cite at least two known ways of reducing the risk of HIV infection *(50% of mothers)*	LQAS 2003	152 hhlds (19 per district)	55%		LQAS 2004	152 hhlds (19 per district)	65%	
					HNS 2004	1,739 married women 454 mothers of children 0-23 months	25.0% (n=435) 22.5% (n=102)	

	Baseline				Final			
Percentage of mothers of children 0-23 months who claim they wash their hangs with soap/ash before food preparation, before feeding children, and after defecation, and after attending a child who has defecated *(25% increase)*	HNS 2001				HNS 2004	467 mothers of children 0-23 months	*Wash hands with soap appropriately:* Before preparing food: 74.5% (n=348) Before feeding child: 52.0% (n=243) After defecation: 43.5% (n=203) After attending a child: 49.9% (n=233)	
	LQAS 2003	152 hhlds (19 per district)	80%		LQAS 2004	152 hhlds (19 per district)	85%	

II. INCREASED AVAILABILITY OF SERVICES (INCLUDES GMP, IODIZED SALT DISTRIBUTION, HIV/AIDS PREVENTION)

Component/Objective/Indicator	Baseline				Final			
	Data source	**Sample size**	**Value**	**Comments**	**Data source**	**Sample size**	**Value**	**Comments (Person responsible to provide – by September 30)**
Percent of children 0-23 who are underweight (-2 SD from the median weight for age according to WHO/NCHS reference population) (*10% reduction*)	HNS 2001	1,572 children <5 years	35%		HNS 2004	439 children 0-23 months 1,100 children <5	23.9% (n=105) 23.1% (n=254)	

	Baseline				Final			
Percent of children 0-23 months of age whose weight and height are charted at least once every two months	LQAS 2003	152 hhlds (19 per district)	75%	GMP start date June 2002; Only weights are recorded	LQAS 2004	152 hhlds (19 per district)	65%	
					HNS 2004	422 children 0-23 months	59.4% (n=251)	
Percent of children 0-5 years with urinary iodine levels >100mg	--	--	--		HNS 2004	483 children 0-5 years	69.8% (n=337)	
Percent of children aged 6-7 years with urinary iodine >100mg *(25% reduction)*	HNS 2001	1,446 children 6-12 yrs	46.7%		HNS 2004	716 children 6-12 years	69.3% (n=496)	
Percent of pregnant women with urinary iodine >100mg	--	--	--		HNS 2004	99 pregnant women	75.8% (n=75)	
Percentage of salt available in shops in the project area with recommended levels of iodine (at least 30 PPM) *(90% of beneficiaries have access)*	IS LQAS Dec '01	160 hhlds (20 per district)	48.6%	Question is 'Do you have iodized salt available in your area to buy?'	IS LQAS Apr '04	152 hhlds (19 per district)	70.4%	Question is 'Do you have iodized salt available in your area to buy?'
					LQAS salt storehouses Apr '04	19 samples in 8 store houses	100% had levels 35-75 PPM	
Percentage of households with salt with recommended levels of iodine (at least 25 PPM)					HNS 2004	2,355 tested households	77.3% (n=1820)	

	Baseline				Final			
	LQAS Nov. 2003	152 hhlds (19 per district)	73%	Note: used Republican levels of 35-65 PPM	IS LQAS Apr '04	152 hhlds (19 per district)	75%	
Percentage of housewives who can recognize the iodized salt logo	--	--	--	Logo developed September 2002				
Percentage of mothers of children 0-23 months who cite at least two known ways of reducing the risk of HIV infection *(50% of mothers)*	LQAS 2003	152 hhlds (19 per district)	55%		LQAS 2004	152 hhlds (19 per district)	65%	
					HNS 2004	1,739 married women 454 mothers of children 0-23 months	25.0% (n=435) 22.5% (n=102)	

III. IMPROVED QUALITY OF SERVICES (INCLUDES INCREASED FAMILY PLANNING CHOICES, STI PREVENTION, DECREASED MICRONUTRIENT DEFICIENCIES)

Component/Objective/Indicator	Baseline				Final			
	Data source	Sample size	Value	Comments	Data source	Sample size	Value	Comments
Percent of children 6-23 months with hemoglobin levels >11 g/dl (normal) *(20% reduction)*	HNS 2001	176 children 6-24 mos.	54.5%		HNS 2004	316 children 6-23 months	Corrected: 62.7% (n=198) Uncorrected: 82.3% (n=260)	Corrected using Hurtado's altitude correction factor

	Baseline				Final			
Percent of pregnant women with hemoglobin levels >11 g/dl (normal) *(20% reduction)*	HNS 2001	228 pregnant women	66.2%		HNS 2004	122 pregnant women	Corrected: 67.2% (n=82) Uncorrected: 82.0% (n=100)	Corrected using Hurtado's altitude correction factor
Percent of children aged 6-12 years who received at least one course of antihelminths last year				The project could not calculate this indicator from MN reports as our target groups subdivided as: children 2 to 5 years, and above 5 years and all other.	HNS 2004	1,763 children 6-12 years	92.3% (n=1,627)	
Percent of children aged 6-23 months who are given at least three weekly doses of micronutrients during pill distribution months	MN report May 2003	228 medical facilities	Vit A- 21263 (99,1 % - children 1 week- 59 months) Vit D-21263 (99,1 % children 1 week- 59 months) Iron folic acid tablets- 19655 (99, 5 % children 6 – 59 months)	Difference between age groups in indicator and project dates	MN report May 2003	228 medical facilities	Vit A- 17615 (99,1 % - children 6- 59 months) Vit D-19225 (99,2 % children 1 week- 59 months) Iron folic acid tablets- 17615 (99,1 % children 6 – 59 months)	Difference between age groups in indicator and project dates
Percentage of women who have their consumption of iron folate checked at least twice during ANC visits				Baseline would be 0%				Dr. Zebogul - RHCS
Percent of pregnant women whose iron folate was checked during CHP visits				Baseline would be 0%				Dr. Zebogul - RHCS

	Baseline				Final			
Percent of women who consumed full recommended course of iron folate during pregnancy (according to project distribution – 52 tablets; 2 tablets per week for 6.5 months)				The project checked only receiving of tablets during monitoring. We did not monitor compliance coverage during 6.5 months.	HNS 2004	943 women with live birth in last five years 116 pregnant women	Received iron tablets: 77.0% (n=726) Received iron tablets: 55.2% (n=64)	
Percent of children 24-59 months with vitamin A deficiency (as measured by maternal report of night blindness) *(25% reduction)*	HNS 2001	952 children 24-59 months	2.0%		HNS 2004	422 children 24-59 months	1.9% (n=8)	
Percent of women who received at least one dose of vitamin A within two weeks after labour					HNS 2004	943 women with live birth in last five years	Within 40 days: 39.8% (n=375) After 40 days: 22.9% (n=216) Never/Don't know: 37.3% (n=352)	
	MN report May 2003			The report shows only women who received Vit A at the moment of distribution. As Nutrition Consultant mentioned in his report it is only 10-15 % coverage.	MN report May 2004			The report shows only women who received Vit A at the moment of distribution. As Nutrition consultant mentioned in his report it is only 10-15 % coverage.

	Baseline				Final			
Percentage of mothers of children 0-23 months who cite at least two known ways of reducing the risk of STI infection	HNS 2001	966	62.9% - one partner 17.9% - use condoms 9.3% - abstain from sex		HNS 2004	453 mothers of children 0-23 months	15.9% (n=72) Use condoms: 40.8% (n=185) One partner: 19.2% (n=87) Abstain from sex: 14.6% (n=66)	
	LQAS 2003	152 (19 per district)	55%		LQAS 2004	152 (19 per district)	60%	

ANNEX 2 - SUMMARY LIST OF RECOMMDENDATIONS

1. Supervision and support structures need to be reinforced to increase the ownership of and responsibility for the community and PHC program by DOH counterparts:
   - The CHP and GMP roles should be combined into one person who will be responsible for both sets of activities. AKF should negotiate with each district for an adequate but affordable number of CHPs for coverage (a rationalized approach to CHP coverage)
   - The PHC centers should be increasingly responsible for both routine monitoring and refresher training of the community volunteers. They (possible along with VO representatives)will need to be included in all training activities to encourage this effort. They will also need training in training methods (participatory adult learning)
   - The CHP reporting system should go through the PHC centers to the District Monitor and the Chief Doctor. AKF may receive reports from the District Monitors, since this should be their primary point of collaboration.
   - A CHP supply system through District Monitors and PHC staff should be strengthened. (condoms, brochures, ORS (and micronutrients?)).
   - If possible, the program centers should be involved with supporting refresher training. They should also be encouraged to collaborate more among each other and with the Districts.
   - For Khorog Town, the link between the CHPs and their VOs for community mobilization should be reinforced, but the link between CHPs and the department Centers for technical support and reporting should also be developed.
2. Strengthen the vision that the VO / health committee, CHP and med-point staff work as one team to improve health in the community.
   - Continue coordinate efforts with MSDSP to integrate community volunteer activities with those of the health committees.
   - Encourage the VO (health committee?) to review salt distribution responsibilities and controls.
   - Involve the VO in med-point oversight and financial accountability, including making the local government budget more transparent.
   - May need to expand and strengthen health committee.
   - Discuss the possibility of including health staff in MSDSP trainings on management and statistics
3. The project may need to "market" the benefit of CHPs to higher level decision makers both within the organization and in government to assure their inclusion in planning and budget
4. Train PHC staff and CHPs to use their own data (registers and utilization data) to track trends and progress. (e.g. review utilization data, morbidity trends, family planning users, skilled deliveries, etc.)
5. Strengthen micronutrient distribution for provision as part of routine care:
   - Use ORS and condom supply system for micronutrient distribution to PHC centers (see CHP recommendations)

- Assure supply either through the RPPM and/or Government of Tajikistan using existing distribution networks.
- Integrate monitoring with other PHC monitoring

6. Advocate with MOH to allow trained and certified nurses (in addition to doctors and midwives) insert IUDs to improve access.
7. AKF and DOH should send a joint letter to Unicef requesting vials with fewer BCG doses.
8. Depending on the availability of funding, a safe motherhood initiative also including newborn care should be undertaken.
9. Continue to work with the Centers to encourage implementation of IMCI as well as Community IMCI (an integrated approach at the community level) to better integrate both program and training.
10. Continue to work on implementing HIV testing including promotion of its availability throughout the districts.
11. During the next phase, an effort should be made to include local hospitals and the Polyclinic on new messages to assure consistent messages and practices between health service providers and community volunteers.
12. Carry out a needs assessment in Khorog town to determine priority health information needs.
13. Encourage (test?) free market salt distribution system in Khorog – build demand, increase consumer knowledge, and increase distribution points. (competition should keep the price down)
14. Develop counseling as an integrated component with all training topics.

LESSONS LEARNED

1. In a literate society, use of brochures and emphasis on data are both feasible and effective.
2. CHPs and health workers agreed that group gatherings were the most effective way to do health education.
3. PHC and health provider staff need the same training as community staff to assure consistent messages as well as to encourage their collaboration with and support of community activities.
4. Access to new knowledge and strong monitoring support may be the most important elements for motivation and quality at both community and facility levels.

ANNEX 3 – CORE EVALUATION TEAM MEMBERS

Marcie Rubardt and Lea Bethune, Co-Team Leaders

9. Zoirbek Kurbonshoev – Health Sector Reform
10. Malohat Shoinbodova, Evaluation, Learning and Communication Officer
11. Shukurbekova Irina – GMP Officer
12. Sadonshoeva Guldarbogh – Monitoring Officer
13. Zarifkhonova Zebogul – Communication and Training Officer
14. Sherzamonova Nozanin – Chief Pharmacist
15. Alibekov Alibek – RPPM Project Manager
16. Ian Higenbothom - AKF Intern

Additional program staff were involved with development of conclusions and recommendations.

ANNEX 4 - EVALUATION SCHEDULE

DATE	ACTIVITIES	PEOPLE CONTACTED
Sun. Oct. 18	• Arrival in Dushanbe • Orientation meeting with evaluation organizers	
Mon. Oct. 19	• Meeting with AKF Senior staff • Meeting with evaluation team – discussion evaluation goals and finalizing tools.	• Wendy Darby, Acting CEO
Tues. Oct. 20	• Meeting with AKF Finance • Meeting with WHO • Finalize evaluation plans • Meeting with Mary Helen Carruth	• Nazira Pulatova, WHO Liaison Officer • Mary Helen Carruth, previous AKF Communications Advisor
Wed. Oct. 21	Travel to GBAO	
Thurs. Oct. 22	• Meeting with Regional Health Office • Meeting with Governor Office • Introduction meeting with Khorog health staff	• Dr. Alimajarov Davlatbek, Head of health Department of GBAO • Dr. Saidek Davlatbekov, Head of Planning, GBAO • Rustamova Fasilat, Deputy Governor GBAO
Fri. Oct. 23	• Meeting with DOH Planning Unit • Meeting with GBAO Specialty Centers	• Dr. Saideck Davlatbekov, Head of Planning • Dr. Zoirbek • Zulfiya Guesmadshoeva • Gulnor Zoirbenova, Head of CDD • Zebo Shodmonova , Representative of Reproductive Health • Hafiz Alamshoev , Head of Center for Healthy Lifestyle • Bodurbenov Bodurben , Head of HIV Department
Sat. Oct. 24	• Meeting with Head of AKHS • Meeting with AKF RHCS staff • Meeting with MSDSP	• Dr. Baig, Head of AKHS • Head, MSDSP • Social Mobilization Officer • District Head, Roshan
Sun. Oct. 25	Travel to Murghab District Field visits in Bununkul and Alichur	• Interviews with mothers, PHC staff, CHPs, GMPs
Mon. Oct. 26	Meetings in Murghab	• Dr. Kochanov Turabek, Chief Doctor • CHPs, mothers • Zulfiya Maskaeva, District Monitor • Garibmamadov Sukrob, MSDSP
Tues. Oct. 27	Field visit to Vashkomvitz Travel to Khorog	• Interviews with PHC staff and CHP
Wed. Oct. 28	Field visit to Ishkashim District Field visit to Kozideh District	• Meeting with Deputy Hukumat Officer • Group interview with 3 District Monitors • Group interview with 5 CHPs • Meeting with MSDSP • Interviews in Kozideh PHC – Head doctor and health staff • Interviews with CHPs, GMPs, and

		mothers
Thurs. Oct. 29	Field Visit to Roshtkala Field visit to Tusian Village	• Meetings with Chief Doctor, Head of Hukumat • Group interviews with District Monitors and CHPs • Interviews with PHC staff • Interviews with mothers and CHP/GMP
Fri. Oct. 30	Group interview with Khorog CHPs Team debriefing of data collected Meeting with Acting RHCS Manager	• Kate Straub , Acting RHCS Manager
Sat. Oct. 31	Teams work on developing conclusions, strengths, and challenges.	
Mon. Nov. 1	Project staff and teams work on developing recommendations	
Tues. Nov. 2	Workshop with partners and stakeholders to review and adjust conclusions and recommendations	
Wed. Nov. 3	Travel to Dushanbe	• Met with Shazeen, Head of ELC Unit, AKF
Thurs. Nov. 4	Meeting with RHCS Project Manager External debriefing Internal debriefing	• Dr. Mavjigul Azizulloeva • Donor representatives – S INO, Project Hope, Ecco, etc. • Yodgur, Wendy, Shazeen, Katoyon, Kate
Fri. Nov. 5	Meeting with Hlth Program Manager Report writing	Dr. Katoyon Faromuzova

ANNEX 5 - DOCUMENTS REVIEWED

Documents Specific to Child Survival: Maternal and Child Nutrition and Integrated Communications Project, Gorno-Badakhshan Autonomous Oblast, Tajikistan

1. "Detailed Implementation Plan", 2001.
2. Annual Report: October 2001 – September, 2002
3. Annual Report: October 31, 200o – September, 2001
4. End of Mission Report: Mary Helen Carruth. Communications Advisor, November, 2001 – April 2003.
5. Midterm Evaluation

General Program Documents – Child Survival and Matching Grant

1. IEC materials and messages for GMP, CHP, and PHC programs
2. Training materials for GMP and CHP
3. Routine reports and monitoring data from supervision and activity reports
4. Guidelines for supervision and reporting for GMP, CHP, and general monitoring
5. LQAS reports for 2003 and 2004
6. Examples of TV spots aired in Khorog and distributed to districts

Consultant Reports and Special Studies

1. "Trials for Improved Practice to Improve Breast Feeding and Complementary Feeding Counseling" Aga Khan Communications and Nutrition Teams, April, 2003.
2. Focus Group Interviews on Breast Feeding, Contraceptive Choices, STIs and Iodized Salt: Findings and Applications, Aga Khan Program Communications Team, July, 2002.
3. Public Health Expenditure Review 2002, Department of Health and Aga Khan Foundation, GBAO, Tajikistan.
4. "Communication for Behavior Change: Reproductive Health/Child Survival"; Aga Khan Foundation, GBAO, Tajikistan; Marydean Purves, Technical Advisor; October, 2001
5. Vital Indicators for GBAO – based on Health and Nutrition Surveys; 1994, 1996, 1998, 2001, 2004
6. Harvey, Ruth; "Maternal/Child Nutrition and Integrated Communications Project - Review of the Nutrition Program" April, 2003.
7. Archer, Linda; "Review of the Monitoring and Evaluation (M&E) System. MCN/IC, FINAL REPORT; November, 2002
8. Kapil, Dr. Umesh; Nutrition Consultation Report; June, 2004.

Miscellaneous Other

1. *DRAFT* - AKDN Health Programme: Phase II – 2005 – 2010
2. David Pyle, Consultant and Sarah Bandali, Intern: Midterm Evaluation, USAID Matching Grant, Gorno-Badakhshan Autonomous Oblast, Tajikistan; May, 2002

ANNEX 6 - FINAL EVALUATION QUESTION GUIDES –
AKF CHILD SURVIVAL/MATCHING GRANT

MOTHERS

Observations:

- Ask to see their growth monitoring cards.
- Check on availability of iodized salt in the household.

1. **What has the AKF health program done in this community?**
    - Probe extensively – but do NOT list these answers: (GM&P/ Salt availability/ Health education / CHP/ Family planning/ micronutrients/drug availability)

2. **What are you doing now for your health or that of your children that you weren't doing before?**
    - Probe extensively but do NOT list answers: CDD/ARI case management, participation in weighing, change in feeding, practicing FP, delivery with skilled provider, etc.)
    - Are there reasons you find it difficult to do the things they are teaching you to do?
    - Do you use iodized salt at home? Why or why not?

3. **How do you interact with people working in health?**
    - How do you interact with the CHP? What do they do for health?
    - How do you interact with the village organizations? What do they do for health?

4. **What do you think about the services at the health post?**
    - How often do you go there? What kinds of problems do you go there for?
    - What do you like about the service you get there? What don't you like about the service?
    - Are there things that make it difficult for you to go to the health center when you need to? (barriers)

COMMUNITY HEALTH PROMOTERS / VILLAGE ORGANIZATIONS

Observations:

- Ask to see the registers, health education materials or other supplies they may have from the project.
- Review their documentation for the health information system.
- Check on the availability of iodized salt in the village.

1. **What do you see as the greatest benefits or accomplishments of this project?**
   - What are you or your neighbors doing differently as a result of what you have learned?

2. **What do you do for health in your community?**
   - For example - probe but do NOT list: data collection, assistance with immunizations and growth monitoring, health education, salt distribution, referral of sick children, community-wide health efforts, funds to assist with health center needs etc.

   - How do you go about doing health education in the village? What approaches work well? What approaches haven't worked so well? What are the most important messages you emphasize?

   - What do you do with the information you collect? How do you use it?

3. **What training did you receive?**
   - What are some of the main things you have learned about health in this community?
   - What do you do when you find a child who is not gaining weight?
   - Who has diarrhea?
   - Difficulty breathing?

4. **What kind of ongoing support have you had to do the work**?
   - For example - do NOT list: supervision, training, link with health providers, incentives, work with other community partners
   - What additional training or support would have been helpful?

5. **What is your relationship with the health center?**
   - When did you last meet with the health providers? What did you discuss?

6. **What do you like about your health work?** (motivation?)

7. **What recommendations do you have for this project if/when funds decrease?**
   - How can we maintain the benefits of this project after funds decrease?

HEALTH PROVIDERS

Observations:

- Availability of contraceptives, anti-helminthics, micronutrients, health education materials, essential drugs, ORS, vaccines, etc. Have there been problems with stock outs in the past six months?
- Availability of equipment and supplies for sterilization and infection prevention
- Service hours and availability of specific services
- General cleanliness / waste disposal
- Cold chain – refrigerator monitoring and function
- SES: HIV testing situation and supplies

1. **What do you see as the greatest benefits or accomplishments of this project**?

2. **What is different now in this facility?**
    - For example – do NOT list: Supervision? Improved patient health status, better supplies, increased STD / FP patients, etc.)

3. **What has been your role in implementing this project?**
    - For example – do NOT list: improved service delivery; training, monitoring and support of CHPs, health education, promotion of STD prevention and FP, micronutrient distribution, etc.
    - How do you go about doing health education? What approaches work well? What approaches haven't worked so well? What are the most important messages you emphasize?

4. **What training did you receive?**
    - What are you <u>doing</u> differently as a result of what you have learned?
        - What do you do when you find a child who is not gaining weight?
        - What do you do when you find a child who has diarrhea or difficulty breathing?
        - What do you tell a woman who is interested in family planning?
        - What do you do to make sure infections are not transmitted in this facility?

5. **What kind of ongoing support have you had to do your job?**
    - For example - do NOT list: supervision, training, link with project staff, relationship with District monitors, incentives, etc.
    - When was the last time someone from the district District come to visit your center? What did you discuss?
    - What additional training or support would have been helpful?

6. **Can you please explain your system for managing drug supplies?**
   (for example: ordering, storage, problems with stock outs, expiration, and oversight)

- How do you address the problem of patients who can't afford to pay for the drugs they need?

7. **What is your relationship with the communities?**
    - How often do you see the CHPs or VO members? What do you do / discuss when you get together?
    - How has community use of your services changed? How do health service costs affect their demand for services?

8. How do you use the information you or the community volunteers collect?

9. **What recommendations or suggestions do you have for this project?**
    1. How can the benefits be maintained when the money decreases?
    2. What recommendations do you have if AKF would do this project somewhere else?

10. **SES**: How is HIV counseling and testing done? Who does it? How were they trained? What do they find difficult?

PARTNERS (District DOH)

1. **What do you see as the greatest benefits or accomplishments of this project?**

2. **What has been your role in implementing this project? Involvement with:**

- project design
- training
- supervision
- motivation
- use of health information system

3. **How well does your relationship with AKF work?**

- What worked well/ Not so well?
- What are your responsibilities? What are those of AKF?

4. **What training did you receive?**

- How are you using the training to support the work on the ground? (remember both technical and management capacity elements)

5. **What kind of ongoing support have you had to do the work?**

- For example: (do NOT list) supervision, training, link with project staff, relationship with other partners, incentives, etc.
- When is the last time you were visited from the region? What did you discuss?
- What additional training or support would have been helpful?

6. **What is your relationship with the health centers and the communities?**

- How often do you visit them?
- What do you do/discuss when you get together?
- How do you ensure community involvement with the health center?

7. **How do you use the information that is collected in the information system?**

- Who reviews it?
- What are some examples of actions that have been taken as a result of the information generated?

8. **What is your relationship with other partners or people working in health in the district? (**for example, district coordination of HIV activities, UNICEF cold chain, MSDSP for salt, UNFPA for FP, etc.)

9. **How have health sector reforms changed your situation or your practice?**

- What is the impact of cost recovery?

10. **What recommendations or suggestions do you have for this project?**

- How can the benefits be maintained when the money decreases?

11. What have we learned from this project for future implementation of health projects?

District Pharmaceutical

Specifically, how do you help assure effective and sustainable pharmaceutical management?

- (For example – Do NOT list: Control systems – financial, transparency and inventory supervision, regular supply, appropriate prescribing, cost recovery management, parallel drug management systems, etc.)
- What is or should be the role of Tajikpharmacia?

Other Partners

Healthy Lifestyles Unit

1. Can you describe the BCC approach(es) this project has been promoting?
2. What approaches work well?
3. What approaches haven't worked so well?
4. What guidance did you get from the project?
5. What are the most important messages you emphasize?
6. How might you continue these approaches after the end of the project?
7. How have you used the videos made in Dushanbe and how might they be used in the future?

MSDSP

1. **What has been your relationship with the AKF health program?**

2. **What is your role with salt distribution?**
   - Specifically, what have been the successes and challenges with adoption of iodized salt?
   - What control systems are in place and how are they working?
   - What financial support have you been receiving and what will happen now?
   - How will the long term success of iodized salt be assured?

3. **What has been your role in working with community health activities?** (Women's groups, Voluntary Organizations, CHPs, PHC centers)
   - What are some of the initiatives that you get involved in to promote community health?
   - Are you involved in assisting communities to financially support health promotion activities or PHC centers?
   - Could there a stronger role for MSDSP in community health? For example:
     Ensure maintenance of PHC centers?
     Provide oversight to PHC revenues collected?
   - What are some examples of actions that have been taken as a result of the information generated?

ANNEX 7 – FINAL WORKSHOP EXPECTATIONS / CONCERNS

Expectations

1. Mutual understanding between partners on some or all recommendations.**
2. Understand colleagues thoughts on the project – present and future**
3. Strengthen cooperation and contributions for the future****
4. Highlight project successes***
5. Explore relations between the project and the Centers
6. Learn from the evaluation
7. Everyone confirms strengths and challenges
8. Learn about the future of the project
9. Develop recommendations that are realistic with limited resources****
10. Develop recommendations for HSR and hospital services.
11. Redefine roles and responsibilities of AKDN for the short and long term

Concerns

1. Some of the recommendations may not be applied
2. Concern about sustainability and the capacity of the government to absorb the program **
3. What will happen to CHPs
4. What will happen to the Centers
5. Continuation of AKF support
6. Future financial support
7. Not much time in this workshop – we need to focus on the wider picture
8. People will focus on solutions that require money rather than solutions that require cooperation.
9. How to use the recommendations – both government and AKDN
10. The future of health sector reform